

This form consists of six (6) two-ply pages. This is page 1.

Agency Name: \_\_\_\_\_

Agency Telephone Number: \_\_\_\_\_

EDC: \_\_\_\_\_

## PREGNANCY QUESTIONNAIRE

### A. GENERAL INFORMATION

1. Mother's Name and Address: *(Please print)*

_____	_____	_____
Last Name	First	Middle
_____		
Street Address		
_____		
_____	_____	_____
City	State	Zip Code

2. Mother's date of birth: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Medicaid ID#: \_\_\_\_\_

5. Telephone number:  
(home) \_\_\_\_\_  
(work) \_\_\_\_\_  
No phone, or phone is often disconnected.

6. How can we contact you?  
Call home                      Call work  
Write home                    Other: \_\_\_\_\_

7. Are you:  
Single (never married, separated,  
divorced, widowed)  
Married

8. Your race/ethnic origin:  
White                              African-American  
Hispanic                          American Indian  
Southeast Asian                Other: \_\_\_\_\_

9. Do you speak English?  
Very well  
A little  
Not at all

10. Do you read English?  
Very well  
A little  
Not at all

11. Are you in a WIC Program?  
No                                  Location: \_\_\_\_\_  
Yes                                   I was denied  
I just applied                    I don't know about WIC

12. What are your sources of income? *(Please check all that apply.)*

Self	Parents
Partner/Spouse	Alimony
Child support payments	
Unemployment benefits	
Other: _____	

13. Are you employed?

No

Yes

I am a student

If you are employed, what is your occupation?

\_\_\_\_\_

If you are employed, how many hours do you usually work in a week? \_\_\_\_\_

14. What was the last grade you finished in school? \_\_\_\_\_

If in school now do you attend regularly?

No

Yes

I am working on GED or have completed it.

15. Have you in the past, or are you currently, receiving special educational services or exceptional education services?

No

Yes

16. Where do you live?

House/Mobile Home

Apartment

Homeless (includes shelter, hotel, motel)

With other family members or friends

17. How many times have you moved in the last year?

\_\_\_\_\_

18. Name address, and telephone number of parent, guardian, or person to contact in an emergency:

\_\_\_\_\_

\_\_\_\_\_

Street Address

\_\_\_\_\_

City                                  State                                  Zip Code

Telephone number: \_\_\_\_\_

What relation is this person to you? \_\_\_\_\_

## B. ABOUT THIS PREGNANCY

1. How far along are you now?  
\_\_\_\_ weeks (or) \_\_\_\_ months  
I don't know
2. How far along were you when you started seeing a medical provider (doctor, nurse midwife or nurse practitioner) for prenatal care?  
\_\_\_\_ weeks (or) \_\_\_\_ months  
I haven't seen anyone yet  
I have an appointment
3. Have you seen your medical provider at least monthly for this pregnancy?  
No  
Yes
4. Did this pregnancy come less than a year after your last pregnancy?  
No  
Yes
5. Are you pregnant with more than one baby?  
No  
Yes  
I don't know
6. Have you had any early signs of labor?  
No  
Yes
7. Have you gone to the emergency room or hospital for this pregnancy?  
No  
Yes
8. Would you like more information or help with any of these things?  
The baby's growth  
How to eat right during pregnancy  
What to expect during labor and delivery  
Breastfeeding  
How to take care of your infant or older children  
Family planning  
Other: \_\_\_\_\_

## C. YOUR MEDICAL HISTORY

1. Do you have, or have you ever had any of these conditions? *(Please check the boxes that apply to you.)*  
Asthma and taking medication  
Chlamydia or gonorrhea (clap)  
Anemia (i.e., "low blood or iron" of pregnancy)  
Chronic kidney disease  
Diabetes  
Epilepsy or seizures  
Exposure to TB in your household  
Heart Disease  
Eating Disorder  
Hepatitis B  
High blood pressure during pregnancy (e.g., preeclampsia, toxemia)  
Kidney/bladder infections  
Mental health problems  
Physical or sensor disabilities (e.g., deaf or blind)  
Genetic disease (e.g., sickle cell, cystic fibrosis, PKU, hemophilia)  
Syphilis  
Genital herpes  
Other medical problem. If so, list them here:  
\_\_\_\_\_
2. How many times have you been pregnant before this pregnancy? \_\_\_\_ times  
Never
3. Have you had any miscarriages?  
No  
Yes \_\_\_\_ How many?
4. Have you had any abortions?  
No  
Yes \_\_\_\_ How many?  
*(If this is the first time you have ever been pregnant, skip the questions below and answer the questions in Part D. Thank you.)*
5. Have you had twins, or multiple births?  
No  
Yes
6. Have you ever had a C-section?  
No  
Yes

7. Were any of your babies born more than 3 weeks early?  
No  
Yes How many? \_\_\_\_\_
8. Did a doctor ever say you had premature labor that required bed rest, medication, and/or hospitalization?  
No  
Yes How many? \_\_\_\_\_
9. Have you had a stillborn baby (born dead after 20 weeks), or that died soon after birth?  
No  
Yes How many? \_\_\_\_\_
10. Did any of your babies weigh less than 5 pounds at birth?  
No  
Yes How many? \_\_\_\_\_

11. Did any weigh more than 10 pounds at birth?  
No  
Yes How many? \_\_\_\_\_
12. Did any stay more than one day in a special care nursery?  
No  
Yes How many? \_\_\_\_\_
13. When did you start prenatal care during your last pregnancy?  
I did not continue with that other pregnancy  
I did not get any prenatal care  
1st - 3rd month  
4th - 6th month  
7th - 9th month

#### D. TOBACCO, ALCOHOL, MEDICINES AND OTHER DRUGS

1. During the 3 months before you were pregnant, on average, how many cigarettes did you smoke a day?  
More than 2 packs a day  
1 or 2 packs a day  
About a pack a day  
About a half pack a day  
About 4 or 5 cigarettes a day  
I don't smoke
2. On average, how many cigarettes do you smoke a day now?  
More than 2 packs a day  
1 or 2 packs a day  
About a pack a day  
About a half pack a day  
About 4 or 5 cigarettes a day (or 2 to 6)  
I live with someone who smokes  
I don't smoke

*We would like to ask you a few questions about drinking. It will help us take better care of you and your baby. Think back to 3 months **before** you became pregnant. Be sure to include beer, wine, and liquor in your answers to these questions.*

3. How many drinks does it take to make you feel high? \_\_\_\_\_ drinks  
I never drink
4. How much can you hold? \_\_\_\_\_ drinks  
I never drink  
I don't know

5. Have people annoyed you by criticizing your drinking?  
No  
Yes  
I never drink
6. Have you ever felt you ought to cut down on your drinking?  
No  
Yes  
I never drink
7. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?  
No  
Yes  
I never drink
8. **Since you became pregnant**, about how many days in a month do you have 3 or more drinks?  
(If none, write zero.) \_\_\_\_\_ days per month
9. **Since you became pregnant**, about how many days in a month do you have one or more drinks?  
(If none, write zero.) \_\_\_\_\_ days per month
10. Have you taken any prescription drugs since you became pregnant?  
No  
Yes  
(Please list them here.)  
\_\_\_\_\_  
\_\_\_\_\_

11. Have you taken any over-the-counter drugs since you became pregnant?  
 No  
 Yes  
*(Please list them here.)*  
 \_\_\_\_\_  
 \_\_\_\_\_
12. Have you ever injected a non-prescribed drug?  
 No *(Skip to question 15)*  
 Yes
13. Number of different persons with whom you shared intravenous drug needles or syringes, or “works” within the last:  
 10 years \_\_\_\_\_ last 12 months \_\_\_\_\_
14. Do you think any of these persons were infected with HIV (the AIDS virus)?  
 No  
 Yes  
 I don’t know

15. How often did you smoke marijuana or hash during the 3 months before you found out that you were pregnant?  
*(Mark X in only one box.)*  
 Several times a week  
 Several times a month  
 Occasionally, or rarely  
 Never
16. How often did you use cocaine or crack during the 3 months before you found out that you were pregnant?  
*(Mark X in only one box.)*  
 Several times a week  
 Several times a month  
 Occasionally, or rarely  
 Never
17. How often did you use heroin, speed, acid, amphetamines, PCP, inhalants, etc. during the 3 months before you found out that you were pregnant? *(Mark X in only one box.)*  
 Several times a week  
 Several times a month  
 Occasionally, or rarely  
 Never

## E. NUTRITION

1. How much did you weigh before you became pregnant this time? \_\_\_\_\_ pounds  
 How tall are you? \_\_\_\_\_ ft. \_\_\_\_\_ inches
2. What do you weigh now? \_\_\_\_\_
3. Have you ever vomited to control your weight or vomited to feel better after eating too much?  
 No  
 Yes
4. Do you vomit often now?  
 No  
 Yes
5. Are you having any of the following symptoms now:  

Nausea	No	Yes
Heartburn	No	Yes
Constipation	No	Yes
6. When you were not pregnant, did you feel that your weight and your body shape were:  
 About right  
 Overweight/too large  
 Underweight/too small
7. Are you on a special diet **now**?  
 No  
 Yes Kind: \_\_\_\_\_
8. Do you eat corn starch out of the box, laundry starch, paint chips, lots of ice, clay, dirt or other things that are not food?  
 No  
 Yes
9. During the past month did you miss any meals or not eat when you were hungry because there wasn’t enough food or money to buy food?  
 No  
 Yes
10. Do you have a working stove and refrigerator?  
 No  
 Yes

## F. RELATIONSHIPS

1. How do you feel now about being pregnant?  
Very happy  
Unsure--a little bit happy and a little bit unhappy  
Very upset about it
2. How does your husband or partner feel now about you being pregnant?  
Very happy  
Unsure--a little bit happy and a little bit unhappy  
Very upset about it  
He doesn't know I'm pregnant
3. How often did you feel depressed during the last week?  
Rarely (less than 1 day)  
Some of the time (1-4 days)  
Most or all of the time (5-7 days)
4. How many living children do you have? \_\_\_\_\_
5. How many of them are living in your household now?  
\_\_\_\_\_
6. Within the last 12 months, have any of your children been taken from you?  
No  
Yes
7. Have you had sexual contact with any of following:  

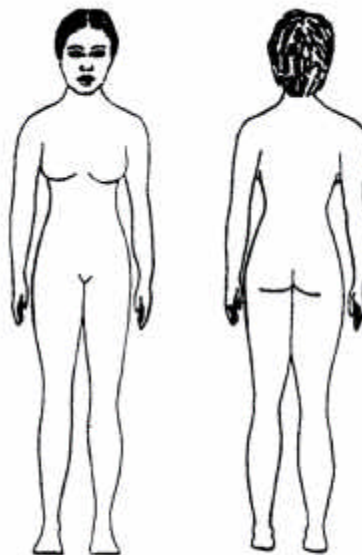
HIV Infected partner?	No	Yes	Not Sure
An IV drug user?	No	Yes	Not Sure
A bisexual partner?	No	Yes	Not Sure
A hemophiliac?	No	Yes	Not Sure
8. Have you given or received money or drugs for sex?  
No  
Yes
9. Does your partner have a problem with alcohol or other drugs?  
No  
Yes
10. Does anyone else in your family have a problem with alcohol or other drugs?  
No  
Yes

What relation is this person to you?

\_\_\_\_\_

11. Have you **ever** been emotionally, verbally or physically abused by your partner or someone close to you?  
No  
Yes
12. Have you been hit, slapped, kicked, or otherwise physically hurt by your partner or someone close to you?  
No  
Yes
13. Since you have been pregnant, were you hit, slapped or kicked, or otherwise physically hurt by someone?  
No  
Yes  
If yes, by whom? \_\_\_\_\_

Mark the place on the picture of the woman to show where you have been hurt by your partner or someone close to you.



Adapted from the March of Dimes

14. Has anyone forced you to have sexual contact?  
No  
Yes  
If yes, by whom? \_\_\_\_\_

15. Have other family members been sexually assaulted or abused?

No  
Yes

16. Are you afraid of your partner or anyone else?

No  
Yes

17. Is there a gun in your home?

No  
Yes

18. Is there someone you can talk to when you have a problem?

No  
Yes

19. How many people can you really count on when you

need help?

No one  
1 - 2 persons  
3 or more persons

List: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

20. What do you do to deal with your problems?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## G. WORRIES

1. Which of these things worry you a lot? (*Check the ones that are big problems.*)

Money problems  
Labor and delivery  
Transportation  
Losing this baby  
My job  
Caring for this baby  
My partner's job, or unemployment  
Caring for my other children  
Housing problems/getting evicted  
Getting child care  
My partner's drinking or drug use  
My health  
My own drinking or drug use  
My own safety  
Worry about my relationship with my partner  
Worry whether this baby will be all right  
My partner is in jail

2. How often do you have problems getting transportation?

Very seldom  
Occasionally  
Quite often  
Most of the time

Please write down here anything else that worries you a lot:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Staff Signature/Date

Points (subtotal) \_\_\_\_\_

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